MEDICARE GEOGRAPHIC CLASSIFICATION REVIEW BOARD

2006 JOINT APPLICATION FOR HOSPITAL GROUPS

FOR GEOGRAPHIC RECLASSIFICATION

EFFECTIVE FEDERAL FISCAL YEAR 2008

PLEASE READ INSTRUCTIONS BEFORE COMPLETING THIS APPLICATION

THIS APPLICATION MUST BE COMPLETED AND RECEIVED BY THE MGCRB BY **5:00 P.M. EDT, SEPTEMBER 1, 2006**. FAILURE TO COMPLY WILL RESULT IN DISMISSAL.

PRINT IN INK OR TYPE WHEN COMPLETING THIS APPLICATION

I. GROUP INFORMATION

1. NAME OF THE COUNTY IN WHICH THE HOSPITALS ARE LOCATED:

_____

2. IDENTIFICATION CODE FOR THE AREA INDICATED IN NUMBER 1 (REFER TO GROUP INSTRUCTIONS):

_____

3. CONTACT FOR ALL COMMUNICATIONS REGARDING THIS APPLICATION:

NAME: _____
ORGANIZATION: _____
ADDRESS: _____

_____
ZIP CODE -
TELEPHONE NUMBER: _____

4. A. THE GROUP SHOULD PROVIDE, USING THE FOLLOWING FORMAT, A LISTING OF ALL IPPS HOSPITALS IN THE COUNTY AT **ATTACHMENT A**. COLUMNS A THROUGH C ARE SELF-EXPLANATORY. FOR COLUMN D., PROVIDE AN ASTERISK IF THE HOSPITAL IS ALSO FILING AN INDIVIDUAL APPLICATION WITH THE MGCRB. IN COLUMN E, THE GROUP MUST IDENTIFY ALL HOSPITALS WHICH ARE ALREADY RECLASSIFIED FOR THE WAGE INDEX IN FFY 2008 AS PART OF A 3-YEAR RECLASSIFICATION. COMPLETE COLUMN E BY INDICATING THE AREA IDENTIFICATION CODE TO WHICH THE HOSPITAL IS RECLASSIFIED IN FFY 2008. **NOTE:** THE BOARD WILL RULE ON A GROUP RECLASSIFICATION REQUEST BEFORE IT RULES ON A HOSPITAL'S INDIVIDUAL REQUEST. IF THE BOARD RECLASSIFIES A GROUP, IT WILL DISMISS ANY INDIVIDUAL RECLASSIFICATION APPLICATION FILED BY HOSPITALS IN THE GROUP.

COL. A HOSPITAL NAME	COL. B ADDRESS	COL. C MEDICARE PROV. NUMBER	COL. D INDIVIDUAL APPLICATION	COL. E FFY 2007 RECLASS. AREA

B. IN SUPPORT OF 4.A. IMMEDIATELY ABOVE, INCLUDE AS **ATTACHMENT B** A CURRENT LETTER FROM THE APPROPRIATE CMS REGIONAL OFFICE WHICH LISTS ALL OF THE CURRENTLY LICENSED IPPS HOSPITALS IN THE COUNTY NAMED IN I.1. ABOVE.

II. RECLASSIFICATION REQUEST

NOTE: PLEASE READ THE ACCOMPANYING HOSPITAL GROUP INSTRUCTIONS FOR THE BOARD'S TREATMENT OF URBAN AND RURAL AREAS.

5. NAME OF THE AREA (RURAL /URBAN AREA) TO WHICH THE GROUP IS REQUESTING RECLASSIFICATION (THE GROUP MAY BE RECLASSIFIED TO ONLY ONE AREA):

_____

6. IDENTIFICATION CODE FOR THE AREA SHOWN IN NO.5 (REFER TO GROUP INSTRUCTIONS)

_____

7. THE GROUP SHOULD CIRCLE THE RECLASSIFICATION CRITERIA UNDER WHICH IT IS APPLYING AND COMPLETE THE SECTIONS INDICATED:

A. ALL HOSPITALS IN A RURAL COUNTY SEEKING REDESIGNATION TO AN URBAN AREA (42 C.F.R. 412.232). COMPLETE SECTIONS III, IV, V, THE WAGE INDEX COMPARISON AND THE AFFIDAVIT (S).

B. ALL HOSPITALS IN AN URBAN COUNTY SEEKING REDESIGNATION TO ANOTHER URBAN AREA (42 C.F.R. 412.234). COMPLETE SECTIONS III, IV, VI, THE WAGE INDEX COMPARISON AND THE AFFIDAVIT (S).

III. GENERAL INFORMATION

8. ARE ALL IPPS HOSPITALS IN THE COUNTY LISTED IN NO. 4 MEMBERS OF THE GROUP?

YES _____ NO _____

9. HAVE THE HOSPITALS IN THE GROUP ALSO REQUESTED RECLASSIFICATION AS A PART OF A STATEWIDE WAGE INDEX APPLICATION FOR FFY 2008?

YES _____ NO _____

10. IF THE GROUP APPLYING FOR RECLASSIFICATION IS AN URBAN GROUP:

A. IS ANY IPPS HOSPITAL IN THE COUNTY CURRENTLY CLASSIFIED BY THE CMS REGIONAL OFFICE UNDER 42 CFR § 412.103 AS BEING IN A RURAL AREA?

YES _____ NO _____

B. DOES ANY IPPS HOSPITAL IN THE COUNTY HAVE A PENDING APPLICATION WITH THE CMS REGIONAL OFFICE TO BE TREATED AS BEING IN A RURAL AREA UNDER 42 CFR § 412.103?

YES _____ NO _____

C. IF THE ANSWER TO 10.A. IS "YES," HAS THE HOSPITAL(S) OBTAINED WRITTEN NOTICE FROM THE CMS REGIONAL OFFICE DEMONSTRATING THAT ITS RURAL REDESIGNATION WILL CANCEL PRIOR TO OCTOBER 1, 2007?

YES _____ NO _____

IF "YES" TO EITHER 10.A., 10.B., OR 10.C., PROVIDE A LIST OF THE HOSPITALS AT **ATTACHMENT C.** ALSO PROVIDE A COPY OF THE APPLICABLE CMS REGIONAL OFFICE APPROVAL LETTER FOR ANY HOSPITAL LISTED IN **ATTACHMENT C** UNDER EITHER 10.A. AND 10.C. (**ATTACHMENT C-1 AND C-3 RESPECTIVELY**) AND THE HOSPITAL'S OWN LETTER REQUESTING CMS REGIONAL OFFICE APPROVAL UNDER 10.B. (**ATTACHMENT C-2**). REFER TO THE INSTRUCTIONS FOR FURTHER DETAIL.

11. IS THE GROUP REQUESTING AN ORAL HEARING?

YES _____ NO _____

IF "YES" ATTACH RATIONALE UNDER **ATTACHMENT D**.

12. PRIOR YEAR GROUP CASE NUMBER (S):

05G _____ 06G _____ 07G _____

IV. ADJACENCY (ALL GROUPS)

13. IS THE COUNTY IN WHICH THE HOSPITALS ARE LOCATED ADJACENT (CONTIGUOUS) TO THE AREA TO WHICH THE GROUP SEEKS REDESIGNATION?

YES _____ NO _____

(ATTACH MAP UNDER **ATTACHMENT E**.)

V. METROPOLITAN CHARACTER (RURAL GROUP ONLY)

14. DOES THE COUNTY IN WHICH THE HOSPITALS ARE LOCATED MEET THE STANDARDS FOR REDESIGNATION TO AN URBAN AREA AS AN "OUTLYING COUNTY"?

YES _____ NO _____

(ATTACH THE SUPPORTING U.S. CENSUS BUREAU DATA UNDER **ATTACHMENT F**.)

VI. CSA/CBSA CRITERIA (URBAN GROUP ONLY)

15. IS THE COUNTY IN WHICH THE HOSPITALS ARE LOCATED A PART OF THE COMBINED STATISTICAL AREA (CSA) OR CORE-BASED STATISTICAL AREA (CBSA) THAT INCLUDES THE URBAN AREA TO WHICH THE GROUP SEEKS REDESIGNATION?

YES _____ NO _____

(ATTACH OFFICIAL U.S. CENSUS BUREAU CSA OR CBSA LISTING UNDER **ATTACHMENT G**.)

WAGE CRITERIA - 85 PERCENT COMPARISON (RURAL AND URBAN GROUPS)

ATTACH THE GROUP'S AGGREGATE HOURLY WAGE COMPUTATIONS USING 3-YEAR AVERAGES OF WAGES AND HOURS FOR THE 85 PERCENT COMPARISON AS **ATTACHMENT H**. TAB 1 OF THE GROUP APPLICATION INSTRUCTIONS PROVIDES AN EXAMPLE OF THIS COMPARISON.

NOTE: AS DISCUSSED IN THE INSTRUCTIONS TO THIS APPLICATION, THE OFFICIAL WAGE DATA USED TO DEVELOP THE FFY 2007 WAGE INDEX AND CORRESPONDING TABLES THAT ARE REQUIRED TO COMPLETE THE WAGE COMPARISON ARE EXPECTED TO BE PUBLISHED IN THE CMS WEBSITE SUBSEQUENT TO AUGUST 1, 2006 AND PRIOR TO OCTOBER 1, 2006. HOAPITAL GROUPS MUST COMPLETE AND SUBMIT THIS SECTION OF THE APPLICATION TO THE BOARD NO LATER THAN 30 DAYS AFTER THE OFFICIAL DATA AND TABLES ARE MADE AVAILABLE ON THE CMS WEBSITE OR SEPTEMBER 1, 2006, WHICHEVER IS LATER. THE OFFICIAL HOSPITAL GROUP APPLICATION FOR FFY 2008 RECLASSIFICATION CONTINUES TO BE DUE ON SEPTEMBER 1, 2006.

AFFIDAVIT

COUNTY OR PARISH OF_____

STATE OF_____

I, _____ (TYPE OR PRINT NAME), BEING DULY SWORN, DEPOSE AND SAY AS FOLLOWS:

(1) I CERTIFY THAT I HAVE EXAMINED THE ACCOMPANYING APPLICATION FOR GEOGRAPHIC RECLASSIFICATION AND ALL OF THE SUPPORTING INFORMATION AND DATA INCLUDED IN THE SUBMITTAL BY _____ _____ (HOSPITAL NAME AND MEDICARE PROVIDER NUMBER) THAT IS DUE TO THE MEDICARE GEOGRAPHIC CLASSIFICATION REVIEW BOARD NO LATER THAN SEPTEMBER 1, 2006. I HEREBY DECLARE UNDER PENALTY OF PERJURY (28 U.S.C. SECTION 1746) THAT THE FOREGOING IS TRUE AND CORRECT.

(2) I UNDERSTAND THAT AN OMISSION, MISSTATEMENT, MISREPRESENTATION, OR ERROR MADE IN A HOSPITAL'S APPLICATION AND SUPPORTING INFORMATION AND DATA FOR GEOGRAPHIC RECLASSIFICATION MAY BE GROUNDS FOR DENIAL OF THE HOSPITAL'S APPLICATION.

(3) I UNDERSTAND THAT AN OMISSION, MISSTATEMENT, MISREPRESENTATION, OR ERROR MADE IN A HOSPITAL'S APPLICATION AND SUPPORTING INFORMATION AND DATA FOR GEOGRAPHIC RECLASSIFICATION MAY BE CAUSE FOR LEGAL ACTION AGAINST THE APPLICANT HOSPITAL AND ITS OFFICIALS.

(4) I CERTIFY THAT I AM AN OFFICER OF THE HOSPITAL NAMED IN (1) ABOVE OR A CORPORATE OFFICER OF THE HOSPITAL'S PARENT CORPORATION WITH AUTHORITY TO SIGN THE APPLICATION FOR GEOGRAPHIC RECLASSIFICATION ON BEHALF OF THE HOSPITAL.

SIGNATURE: _____

TITLE: _____

PHONE NUMBER: _____

SUBSCRIBED AND SWORN BEFORE ME
THIS _____ DAY OF _____2006
(DAY) (MONTH)

_____
(SIGNATURE OF NOTARY)

NOTARY PUBLIC
MY COMMISSION EXPIRES: _____